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**Issue Date: 15 June 2006**

**IN THE MATTER OF:**

SANDRA K. STIDHAM (widow of and on behalf of deceased miner James Stidham),
Claimant,

**v.**

Case Nos.: 2005-BLA-5779
2005-BLA-5780

LEBO MINING COMPANY,
Employer,

**and**

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

**APPEARANCES:** Andrew Delph, Esq.
For the Claimant

Spenser Wiegard, Esq.
For the Employer

**BEFORE:** Thomas M. Burke
Associate Chief Administrative Law Judge

## DECISION AND ORDER DENYING LIVING MINER'S AND SURVIVOR'S BENEFITS

This case arises from claims for benefits filed under the "Black Lung Benefits Act," Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, at 30 U.S.C. § 901 *et seq.* ("Act"), and the implementing regulations thereunder at 20 C.F.R. Parts 718 and 725 (2005). A hearing was held in Abingdon, Virginia on September 27, 2005. At the hearing, however, the parties moved for a decision on the record, which was granted. As a result, the decision in this matter is based on all documentary evidence admitted into the record and the post-hearing arguments of the parties. The documentary evidence admitted at the hearing includes *Director's Exhibits* in the survivor's claim (*SDx.*) 1-31, *Director's Exhibits* in the miner's claim (*MDx.* 1-29), *Claimant's Exhibits* (*Cx.*) 1-3, and *Employer's Exhibits (Ex.)* 1-6. Identification of *Claimant's* and *Employer's Exhibits* are as follows:

CX 1 June 26, 2005 pathological report of Dr. Joshua Perper
CX 2 *Curriculum vitae* of Dr. Perper
CX 3 October 15, 2002 examination report of Dr. J. Randolph Forehand

EX 1 Interpretation of the January 29, 2003 x-ray by Dr. Paul Wheeler
EX 2 *Curriculum vitae* of Dr. Wheeler
EX 3 July 20, 2005 consultative report of Dr. A. Dahhan
EX 4 *Curriculum vitae* of Dr. Dahhan
EX 5 August 31, 2005 pathological report of Dr. Richard L. Naeye
EX 6 *Curriculum vitae* of Dr. Naeye

## ***Overview of the Black Lung Benefits Program***

The Black Lung Benefits Act is designed to compensate those miners who have acquired pneumoconiosis, commonly referred to as "black lung disease," while working in the Nation's coal mines. Those miners who have worked in or around mines and have inhaled coal mine dust over a period of time, may contract black lung disease. This disease may eventually render the miner totally disabled or contribute to his death.

## ***Procedural History***

The miner's claim

1. The miner filed a claim for benefits on April 30, 2002. *MDx*. 2

2. On July 18, 2003, the district director issued a *Proposed Decision and Order – Denial of Benefits*. *MDx.* 22.

3. Claimant filed additional documentation and, on January 20, 2005, the district director issued a *Proposed Decision and Order Denying Request for Modification*. *MDx.* 24. It is not clear why the district director viewed the proposed decision as a denial on modification, but it is noted that one of Dr. DePonte's chest x-ray interpretations is date-stamped as received by the district director on May 5, 2003. *MDx.* 14. The denial was based on Claimant's failure to demonstrate any element of entitlement.

4. By letter dated February 18, 2005, Claimant's counsel requested a formal hearing. *MDx.* 25.

5. The miner's claim was referred to this Office for adjudication on March 3, 2005. *MDx.* 26.

The survivor's claim

1. The survivor filed a claim for benefits on April 9, 2004. *SDx.* 2.

2. The record contains a *Certificate of Marriage* establishing that Claimant and the miner were married on June 8, 1963. *SDx.* 8.

3. A *Certificate of Death*, issued by Dr. Virginia Baluyot on December 8, 2003, provides that the miner died on December 7, 2003 of pneumoconiosis, lung cancer in the left upper lobe, and sepsis. *SDx.* 9.

4. On January 20, 2005, the district director issued a *Proposed Decision and Order Award of Benefits – Responsible Operator*. *SDx.* 23. The district director concluded that coal workers' pneumoconiosis was established based on Dr. DePonte's positive chest x-ray interpretation as well as Dr. David Miller's diagnosis of pneumoconiosis in his medical opinions. The district director further noted that Dr. Baluyot completed the death certificate and found that the miner died due to pneumoconiosis, which was supported by the treatment records of Drs. Guzman, Miller, Smiddy, and Boggin. These records indicated on-going treatment for lung cancer, pneumoconiosis, and chronic obstructive pulmonary disease.

5. Employer submitted a timely hearing request on February 14, 2005. *SDx.* 25.

6. The claim was referred to this Office for adjudication on April 14, 2005. *SDx.* 29.

## ***Issues Presented for Adjudication and Stipulations***

The miner's claim

The issues listed as contested on the CM-1025 in the miner's claim include: (1) whether the miner suffers from pneumoconiosis; (2) arising out of coal mine employment; (3) whether he is totally disabled; and (4) whether the miner's total disability was due to pneumoconiosis. *MDx.* 27.

The survivor's claim

In the survivor's claim, the issues listed as contested are: (1) whether the miner suffered from pneumoconiosis; (2) whether the pneumoconiosis arose out of coal dust exposure; and (3) whether pneumoconiosis hastened the miner's death. *SDx.* 29.

Stipulation – length of coal mine employment

The parties stipulate that Mr. Stidham was engaged in coal mine employment for 34 years. *MDx.* 27; *SDx.* 29.

### *The Standard for Entitlement*

Because this claim was filed after April 1, 1980, it is governed by the regulations at 20 C.F.R. Part 718 (2005).[1] Under Part 718, Claimant bears the burden of establishing each of the following elements by a preponderance of the evidence: (1) the miner suffered from pneumoconiosis; and (2) the pneumoconiosis arose out of coal mine employment. In the miner's claim, Claimant must demonstrate that he was totally disabled and that his disability stemmed from pneumoconiosis. In support of her claim, the widow must establish that pneumoconiosis caused the miner's death. *Gee v. W.G. Moore & Sons*, 9 B.L.R. 1-4 (1986)(en banc); *Baumgartner v. Director, OWCP*, 9 B.L.R. 1-65 (1986)(en banc). Failure to establish any one of these elements precludes entitlement to benefits.

### *Existence of Pneumoconiosis and its Etiology*

Under the amended regulations, "pneumoconiosis" is defined to include both clinical and legal pneumoconiosis:

> (a) For the purpose of the Act, "pneumoconiosis" means a "a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.
>
> > (1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. The definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.
> >
> > (2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.
>
> (b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment

[1] As the miner last engaged in coal mine employment in the Commonwealth of Virginia, appellate jurisdiction of this matter lies with the Fourth Circuit Court of Appeals. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989)(en banc).

significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 C.F.R. § 718.201 (2005). Moreover, the regulations at 20 C.F.R. § 718.203(b) (2005) provide that, if a miner suffers from pneumoconiosis and has engaged in coal mine employment for ten years or more, as in this case, there is a rebuttable presumption that the pneumoconiosis arose out of such employment.

The existence of pneumoconiosis may be established by any one or more of the following methods: (1) chest x-rays; (2) autopsy or biopsy; (3) by operation of presumption; or (4) by a physician exercising sound medical judgment based on objective medical evidence. 20 C.F.R. § 718.202(a) (2005).[2]

When weighing chest x-ray evidence, the provisions at 20 C.F.R. § 718.202(a)(1) (2005) require that "where two or more X-ray reports are in conflict, in evaluating such X-ray reports consideration shall be given to the radiological qualifications of the physicians interpreting such X-rays."[3] In this vein, the Board has held that it is proper to accord greater weight to the interpretation of a B-reader or Board-certified radiologist over that of a physician without these specialized qualifications. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211 (1985); *Allen v. Riley Hall Coal Co.*, 6 B.L.R. 1-376 (1983). Moreover, an interpretation by a dually-qualified B-reader and Board-certified radiologist may be accorded greater weight than that of a B-reader. *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211 (1985); *Sheckler v. Clinchfield Coal Co.*, 7 B.L.R. 1-128 (1984). The following chest roentgenogram evidence is in the record:[4]

| ***Exhibit / Physician/ Radiological Qualifications*** | ***Date of study/ Date of reading*** | ***Film Quality*** | ***Reading*** |
|---|---|---|---|
| *MDx.* 12 Forehand B | 10-15-02<br>10-15-02 | 2 | --; density in left upper lobe |
| *MDx.* 13 Barrett B, BCR | 10-15-02<br>11-12-02 | 1 | Quality reading only |

[2] There is no autopsy or biopsy evidence in this record and the presumptions contained at §§ 718.304 - 718.306 are inapplicable such that these methods of demonstrating pneumoconiosis will not be discussed further.

[3] A"B-reader" (B) is a physician, but not necessarily a radiologist, who successfully completed an examination in interpreting x-ray studies conducted by, or on behalf of, the Appalachian Laboratory for Occupational Safety and Health (ALOSH). A designation of "Board-certified" (BCR) denotes a physician who has been certified in radiology or diagnostic roentgenology by the American Board of Radiology or the American Osteopathic Association.

[4] A "--" under the *Reading* column of the chart indicates that the physician did not provide a specific category reading under the ILO-U/C classification system. 20 C.F.R. §§ 718.102 and 718.202(a)(1) (2001).

| | | | |
|---|---|---|---|
| *SDx*.. 15 DePonte B, BCR | 10-21-02<br>10-21-02 | readable | --; 8 cm left upper lobe mass suspicious for cancer; COPD |
| *SDx*. 15 DePonte B, BCR | 11-11-02<br>11-11-02 | readable | --; large mass in left lung consistent with known carcinoma; underlying changes of COPD |
| *MDx*. 14 DePonte B, BCR | 01-29-03<br>01-29-03 | 1 | 1/0, q/q; "findings consistent with pneumoconiosis"; "diminishing left upper lobe known lung carcinoma" |
| *Ex*. 1 Wheeler B, BCR | 01-29-03<br>03-29-05 | 2 | --; no parenchymal or pleural abnormalities consistent with pneumoconiosis |
| *SDx*. 10 Smiddy B | 02-18-03<br>02-18-03 | readable | --; left upper lobe infiltrate |
| *SDx*. 10 Smiddy B | 05-20-03<br>05-20-03 | readable | -- |
| *SDx*. 15 DePonte B, BCR | 06-11-03<br>06-11-03 | readable | --; left apical changes consistent with known lung carcinoma; COPD |
| *SDx*. 15 DePonte B, BCR | 06-12-03<br>06-12-03 | readable | --; left apical changes consistent with known lung carcinoma; COPD |
| *SDx*. 15 DePonte B, BCR | 07-22-03<br>07-22-03 | readable | --; progressive left apical volume loss consistent with known lung carcinoma; COPD |
| *SDx*. 15 DePonte B, BCR | 10-01-03<br>10-01-03 | readable | --; large left upper lobe lesion consistent with lung cancer; COPD |
| *SDx*. 15 DePonte B, BCR | 10-29-03<br>10-30-03 | readable | --; 9 cm mass in the left apex consistent with known lung cancer; possible pneumonia |
| *SDx*. 15 DePonte B, BCR | 11-03-03<br>11-04-03 | readable | --; left upper lobe carcinoma; COPD |
| *SDx*. 15 DePonte B, BCR | 12-02-03<br>12-02-03 | readable | --; left upper lobe carcinoma |

| | | | |
|---|---|---|---|
| *SDx.* 15 DePonte B, BCR | 12-02-03<br>12-02-03 | readable | --; lung cancer in left upper lobe; irregular 1 to 2 cm opacity at right base that may be due to metastasis or focal infiltrates; underlying changes of obstructive airways disease present |
| *SDx.* 15 DePonte B, BCR | 12-05-03<br>12-05-03 | readable | --; pulmonary edema |
| *SDx.* 15 DePonte B, BCR | 12-05-03<br>12-05-03 | readable | --; "Consolidation remains in the right upper lobe with increased markings in the right lower zone. This may represent pneumonia, pulmonary edema or a combination thereof." |

Based on the foregoing, Claimant has not established that the miner suffered from pneumoconiosis. Of the x-ray studies in the record, dating from October 2002 to December 2003, only one study produced a finding of Category 1 pneumoconiosis. Specifically, Dr. DePonte, who is a dually-qualified physician, concluded that the January 29, 2003 study indicated the presence of Category 1 pneumoconiosis. However, Dr. Wheeler, who is also dually-qualified, found no parenchymal or pleural abnormalities consistent with pneumoconiosis on the study. On balance, this study does not establish the presence or absence of pneumoconiosis. While many of the remaining studies of record confirm the presence of chronic obstructive pulmonary disease and a mass in the miner's left upper lung, which was diagnosed as cancer, none of the remaining studies provide an assessment of the presence or absence of pneumoconiosis. Consequently, Claimant has not sustained her burden under 20 C.F.R. § 718.202(a)(1) (2005).

Claimant may also demonstrate the presence of pneumoconiosis through autopsy or biopsy evidence. 20 C.F.R. § 718.202(a)(2) (2005). No autopsy was conducted in this matter. According to Dr. Smiddy, a bronchoscopy conducted on November 18, 2002 yielded evidence of interstitial lung disease, pneumonia, and a nodular infiltrate at the left sixth rib with a known diagnosis of adenocarcinoma. Dr. Colquitt confirmed the presence of lung cancer after conducting a surgical pathology of the mass in the miner's left lung. No findings of pneumoconiosis were made. Moreover, in his August 31, 2005 report, Dr. Naeye did not find pneumoconiosis in the two bronchial wall tissue samples given to him for review:

> Two rather large birefringent crystals are visible under polarized light. Because of their size such crystals are not fibrogenic. No very tiny birefringent crystals that can be fibrogenic are visible under the highest oil magnification possible with a light microscope. This latter examination was conducted in a room from which

> all external light had been excluded. This result excludes the presence of fibrogenic silica in the lung tissues available for review.

Thus, Dr. Naeye concluded that coal workers' pneumoconiosis was not present in the tissue samples. There is no contrary opinion of record. Claimant has not established the presence of pneumoconiosis under § 718.202(a)(2) of the regulations.

The final method by which Claimant may establish that the miner suffered from the disease is by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts and other data on which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's history. *See Hoffman v. B&G Construction Co.*, 8 B.L.R. 1-65 (1985); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295 (1984).

A "reasoned" opinion is one in which the administrative law judge finds the underlying documentation adequate to support the physician's conclusions. *Fields, supra*. Indeed, whether a medical report is sufficiently documented and reasoned is for the administrative law judge as the finder-of-fact to decide. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989)(en banc). Moreover, statutory pneumoconiosis is established by well-reasoned medical reports which support a finding that the miner's pulmonary or respiratory condition is significantly related to or substantially aggravated by coal dust exposure. *Wilburn v. Director, OWCP*, 11 B.L.R. 1-135 (1988). The following medical reports were admitted as evidence in the record:

Dr. Joseph F. Smiddy

Dr. Smiddy treated the miner for his cancer and other pulmonary and respiratory conditions. *SDx.* 10. Dr. Smiddy's treatment records cover a period of time from October 2002 until the time of the miner's death in December 2003. These records primarily relate to diagnosis and treatment of the miner's lung cancer. On November 13, 2002, Dr. Smiddy issued a treatment report wherein he noted a history of working around "coal dust" and that the miner smoked until the age of 45 years. Dr. Smiddy concluded as follows:

> At this point, the patient has a complex history with a large adenocarcinoma, associated pneumonia, COPD and poor performance status with oxygen dependence. The patient may have acute pneumonia superimposed upon lung cancer and COPD.

*SDx.* 10.

A November 18, 2002 report of bronchoscopy contains the following findings from Dr. Smiddy:

> Interstitial lung disease bilaterally with honeycombing, apparent lower lobe and left upper lobe pneumonia. The pneumonia has a nodular character, and the

> patient has a nodular infiltrate behind the anterior projection of the left sixth rib (known history of recent diagnosis of adenocarcinoma).

*SDx.* 10.

On November 25, 2002, Dr. Smiddy reported that an October 21, 2002 CT-scan revealed an 8 centimeter left upper lobe mass and a subsequent bronchoscopy revealed the presence of lung cancer.[5] Dr. Smiddy stated the following:

> The patient has terrible performance status with hypoxia at rest and oxygen dependence. The patient at this time is not a good candidate for surgery, chemotherapy, and/or radiotherapy and may have a very guarded prognosis.

By report dated December 9, 2002, Dr. Smiddy diagnosed the presence of chronic pneumonia, chronic obstructive pulmonary disease, lung cancer, and "almost certainly a lung abscess."

Dr. Smiddy had a whole body PET scan conducted on December 18, 2002 and reiterated that the mass in the left upper lobe of the miner's lung was suspicious for carcinoma.

A December 16, 2002 CT-scan of the miner's chest revealed a left upper lobe mass suspicious for lung cancer as well as "patchy-ground glass opacities throughout the left lung." This "potentially represent(ed) radiation pneumonitis, pulmonary hemorrhage, or atypical pneumonia."

By report dated February 18, 2003, Dr. Smiddy stated that an x-ray study seemed to reveal "less left upper lobe infiltrate and less left lung prominence of markings than (the miner) had on his prior film 12-09-2002." Dr. Smiddy found an element of interstitial fibrosis, but noted improved breath sounds since the miner's last visit.

On May 20, 2003, Dr. Smiddy noted that the miner's lungs were "stable and improved without rales, rubs, or rhonchi." An x-ray study revealed a stable left upper lung mass. The diagnosis remained lung cancer.

Dr. Smiddy is board-certified in internal medicine. *SDx.* 10.

Dr. David Miller

Dr. Miller, of the Southwest Virginia Regional Cancer Center, provided treatment for the miner's lung cancer. *SDx.* 10 and 15. On December 23, 2002, he noted a history of lung cancer, chronic obstructive pulmonary disease, pneumonia, pneumoconiosis, and smoking (but not recent). Examination of the lungs revealed no cough, chest pain, or shortness of breath. Dr.

[5] In a report dated November 19, 2002, Dr. Landon Colquitt conducted a surgical pathology of the lung mass observed on x-ray and confirmed the presence of lung cancer and mild to moderate chronic inflammation. *SDx*. 12.

Miller recommended that the miner undergo chemotherapy alone for his lung cancer considering his "recent dyspnea."

By report dated January 28, 2003, Dr. Miller diagnosed on-going lung cancer, chronic obstructive pulmonary disease, pneumoconiosis, a history of smoking, and hemoptysis and fever due to post-obstructive pneumonia and tumor. Dr. Miller observed a "process" in the right upper lung that could be due to pneumoconiosis, but the "[s]taging work-up (was) incomplete." He reported shortness of breath on exertion and that the miner used oxygen. The miner stated that he felt better after the start of chemotherapy. Examination of the lungs revealed that they were "clear" to percussion and auscultation.

On February 19, 2003, Dr. Miller issued a supplemental report. He noted that the miner had been diagnosed as suffering from lung cancer, hemoptysis and fever, leukocytosis, smoking, pneumoconiosis, and chronic obstructive pulmonary disease. There was no reasoning or reference to testing in support of these diagnoses. The lungs were clear to percussion and auscultation and the heart had "regular rhythm." The miner reported less coughing and less shortness of breath; he had "reduced oxygen down to one liter per minute."

Similar findings were offered by Dr. Miller in a March 12, 2003 report. In this report, he noted that CT-scans conducted on March 5, 2003 demonstrated slight progression of the cancer in the lungs, but no apparent progression to other parts of the miner's body. The miner denied chest pain or shortness of breath and Dr. Miller concluded that he was responding well to the chemotherapy. He stated that the miner had no recurrent pneumonia, and his bone pain was resolved. Dr. Miller continued to diagnose the presence of chronic obstructive lung disease and pneumoconiosis, among other ailments.

In a report dated April 2, 2003, Dr. Miller reiterated that the miner suffered from lung cancer and that he had a "continued tendency to pulmonary infections probably indicating continuing presence of tumor with narrowing of the airway." Although Dr. Miller continued to diagnose the presence of chronic obstructive pulmonary disease, he did not include pneumoconiosis among the list on diagnosed conditions in this report.

Finally, on May 27, 2003, Dr. Miller noted that there was evidence that the miner's lung cancer had improved after radiation therapy. The miner continued to suffer from peripheral neuropathy, anemia of chronic disease, constipation, and he had a history of chronic obstructive pulmonary disease. Again, Dr. Miller did not mention the presence of pneumoconiosis in this report.

Terminal hospitalization

The miner was last hospitalized at Bon Secours St. Mary's Hospital from December 2-7, 2003. *SDx.* 15. Dr. Paul Barongan provided the miner's history on admission. He noted the following:

> The patient is married. He worked underground in the mines for 35 years. He retired in October before he got sick. The doctor told him he has pneumoconiosis,

> but the company says he does not have any pneumoconiosis. Since he is retired, he has been unable to enjoy his retirement because he got sick immediately.

Dr. Barongan noted that the miner's history was significant for chronic obstructive pulmonary disease and bronchogenic carcinoma of the left lung. Examination of the lungs revealed diminished breath sounds and bibasilar rales, especially in the left lung. No wheezing was heard. Dr. Barongan diagnosed "[a]cute bronchitis with exacerbation of COPD, possible right lower lobe infiltrate or metastasis. Bronchogenic CA. Anemia."

Dr. Barongan is board-certified in pediatrics.

On December 5, 2003, Dr. Francis Jaynal provided a consult for "[r]apid supraventricular tachycardia with hypertension." Dr. Jaynal diagnosed hypotension, most likely secondary to septic shock, acute onset of rapid atrial fibrillation, bilateral pneumonia, left lung cancer, anemia, and acute respiratory failure. The miner was under heavy sedation. Examination of the lungs revealed "[h]arsh breath sounds with bilateral rhonchi." The miner's prognosis was poor and his condition was considered "critical."

The miner died on December 7, 2003. The principle diagnosis was pneumonitis due to inhalation of food or vomitus. The secondary diagnoses were acute respiratory failure, unspecified septicemia, malignant neoplasm of the lung, atrial fibrillation, pulmonary congestion and hypostasis, hypotension, anemia in neoplastic disease, asphyxia, and depressive disorder.

Dr. J. Randolph Forehand

Dr. Forehand examined and tested the miner and issued a report on October 15, 2002. *MDx.* 9. He noted 34 years of coal mine employment as well as a history of smoking one-half a pack of cigarettes per day from 1970 to 1985. The miner complained of a daily productive cough, wheezing, dyspnea, and hemoptysis. Examination of the lungs yielded no abnormal findings. Cardiac examination was normal. A chest x-ray was interpreted as negative for coal workers' pneumoconiosis. Ventilatory and blood gas testing produced non-qualifying values. An EKG yielded no evidence of acute changes. Dr. Forehand concluded that there was no evidence that the miner suffered from coal workers' pneumoconiosis. He did note a pulmonary mass on the x-ray and concluded that it was necessary to rule out tuberculosis or a malignancy. He concluded that the miner suffered from no respiratory impairment.

Dr. A. Dahhan

Dr. Dahhan conducted a review of certain medical records and issued a report on July 20, 2005. *Ex.* 3. He concluded that the medical records did not support a finding of coal workers' pneumoconiosis. According to Dr. Dahhan, none of the chest x-rays showed the presence of the disease. Moreover, he noted that the December 9, 2002 and May 20, 2003 ventilatory studies were non-qualifying. Dr. Dahhan concluded the following:

> Mr. Stidham died as a result of adenocarcinoma of the lung and its complications, which eventually led to the development of pneumonia, cardiac arrhythmia, hypotension, shock and death.

Further, Dr. Dahhan states:

> The records indicate no evidence of pulmonary impairment and/or disability caused by, related to, contributed to or aggravated by the inhalation of coal dust or coal workers' pneumoconiosis as documented by the pulmonary function studies, clinical examination of the chest and chest x-rays.

Dr. Dahhan concluded that the miner's death stemmed from complications of lung cancer and was not hastened by the presence of coal workers' pneumoconiosis.

Dr. Joshua Perper

Dr. Perper conducted a review of certain medical records, including the pathological report of the left upper lobe biopsy, and issued a report on June 26, 2005. *Cx.* 1. In his report, Dr. Perper notes a 34.3 year history of coal mine employment as well as a history of smoking one pack of cigarettes every two days from 1970 to 1985, which was based on information gathered in Dr. Forehand's October 15, 2002 examination report.

Dr. Perper also reviewed the miner's terminal hospitalization records and noted that the principal diagnosis at the time of death was pneumonitis due to inhalation of food or vomitus with numerous other secondary diagnoses. He also noted that the miner had been on continuous mechanical ventilation for "less than 96 consecutive hours." A death certificate signed by Dr. Baluyot listed the causes of death as pneumoconiosis, lung cancer, and sepsis.

Dr. Perper noted that the miner's 34 years of employment in the coal mines constituted a "much more than sufficient period of exposure to mixed coal dust, to account for the development of coal workers' pneumoconiosis." Citing to various publications, he stated that "[s]uch length of occupational exposure to coal dust containing silica is well recognized to be more sufficient for the development of occupational coal workers' pneumoconiosis." Dr. Perper noted that Dr. DePonte specifically found "the presence of coal workers' pneumoconiosis on October 21, 2002 and February 14, 2003" and she diagnosed the presence of chronic obstructive pulmonary disease on numerous chest x-ray and CT-scans. Further, Dr. Perper reported that Dr. Miller diagnosed lung cancer as well as "coal workers' pneumoconiosis on several occasions" in his December 23, 2002, January 28, 2003, February 19 and March 12, 2003 reports.

Dr. Perper stated that "[t]he miner had symptoms of respiratory difficulties for four years prior to the diagnosis of pulmonary cancer, including shortness of breath on mild exertion for the prior four years and cough with expectoration of dark phlegm and occasional wheezing." Finally, Dr. Perper stated:

> In addition to pneumoconiosis the lungs showed lung cancer and centrilobular emphysema, conditions associated with both cigarette smoking and exposure to mixed coal dust containing silica.

From this, Dr. Perper maintains that centrilobular emphysema is a known complication of smoking as well as coal dust exposure and he cites to certain medical publications as well as the Department's comments to the amended regulations at 20 C.F.R. Part 718 (2005).

Dr. Perper opines that coal workers' pneumoconiosis was a substantial contributory cause of death and hastened the miner's death. He stated that the miner suffered from lung cancer "on the background of simple coal workers' pneumoconiosis" and that the miner's cancer stemmed from smoking history as well as his "significant coal workers' pneumoconiosis and occupational exposure as a miner to mixed coal dust containing silica." He stated that coal workers' pneumoconiosis, as well as the lung cancer and centrilobular emphysema stemming from the disease, "were effective causes of death which resulted in pulmonary damage and impairment and terminal acute bronchopneumonia."

Dr. Perper is board-certified in anatomical, surgical, and forensic pathology. *Cx.* 2. He currently serves as a Clinical Professor of Pathology and Clinical Professor of Epidemiology and Public Health at the University of Miami, Florida. He is also an Adjunct Professor of Anthropology at the Florida Atlantic University School of Anthropology. Dr. Perper is the author of numerous publications and has served in a variety of editorial positions of medical journals.

Dr. Richard Naeye

Dr. Naeye reviewed certain medical records and two slides of tissue from the bronchial wall and adjacent tissues and issued a report on August 31, 2005. *Ex.* 5. He reported that the miner worked 34.4 years in the coal mines and quit on October 22, 2002. Moreover, he noted that the miner smoked two packs of cigarettes per day until quitting at the age of 45 years. Dr. Naeye stated that "[v]ery shortly after he quit mining coal an x-ray detected the presence of a lesion in the upper lobe of his left lung" that was later diagnosed as lung cancer. Dr. Naeye stated that the miner's medical records did not demonstrate the presence of pneumoconiosis:

> Despite radiation and chemotherapy the neoplasm advanced and (the miner) died on December 7, 2003. Chest x-rays in 2003 were interpreted as showing evidence of obstructive pulmonary disease in addition to the neoplasm. No x-ray reports available to me clearly identify the presence of coal workers' pneumoconiosis in addition to the fatal neoplasm.

Dr. Naeye also reviewed Dr. Perper's report. He noted that Dr. Perper incorrectly recorded a smoking history of one pack of cigarettes every two days from 1970 to 1975, as that the miner actually had a history of smoking two packs of cigarettes per day until the age of 45 years. Dr. Naeye stated that, assuming the miner began smoking at the age of 18 years, he would have had a 54 pack year smoking history. Dr. Naeye further noted that, at the time the lung cancer was diagnosed in October 2002, the miner's blood gas and ventilatory study values were normal and

Dr. Forehand found no coal workers' pneumoconiosis. Moreover, a biopsy of lung tissue failed to reveal the presence of pneumoconiosis. The December 2002 PET scan demonstrated "likely metastases of the neoplasm to right lung hilar and pericardial areas." Also, the miner suffered from "post-obstructive pneumonia" that was only "partially cleared" on December 23, 2002 and he was receiving supplemental oxygen at the time. Also, as previously noted, Dr. Naeye did not find coal workers' pneumoconiosis present on two tissue samples from the miner's bronchial wall. Finally, Dr. Naeye noted that the miner "survived for nearly a year after the cancer was diagnosed":

> He died on 12/7/03. No autopsy was performed. Despite no postmortem examination, X-ray or any other direct evidence Dr. Virginia Baluyot put 'pneumoconiosis' first on a list of causes of death. There is no evidence whatsoever that coal workers' pneumoconiosis (CWP) was present in the lungs of this man. The other two causes of death Dr. Baluyot listed were lung cancer and sepsis. Again, there is very strong evidence that coal workers' pneumoconiosis (CWP) was absent in the lungs of this man. Toxic silica being absent, coal mine dust could not have caused significant emphysema as claimed by Dr. Perper. In short, Dr. Perper claims in his report the presence of serious lung diseases that were absent prior to the advent to cigarette smoking induced lung cancer.

With regard to development of the miner's lung cancer, Dr. Naeye denied that the cancer was attributable to exposure to coal dust. He reasons the following:

> Dr. Perper attributes the lung cancer to occupational exposures to coal mine dust. This is not consistent with the facts. Large amounts of silica can cause lung cancer, but no such silica is visible in the lung biopsy tissues of James Stidham. Finally, neither U.S. nor European coal miner's have been found to have an increased frequency in any form of lung cancer when cigarette smoking is taken into consideration. (citations omitted). In fact, U.S. coal miners reportedly have a lower frequency of lung cancer than is present in the general population. (citation omitted). The distribution of cancer cell types in coal workers is similar to that in the general population. (citation omitted). There are a large number of other studies which also show no relationship between mining coal and lung cancer. (citations omitted). The Assistant Surgeon General of the U.S. has testified before a congressional committee that 'an increase in lung cancer in coal miners has not been documented. (citation omitted). Finally, the World Health Organization & many others have concluded that exposure to coal mine dust does not increase the frequency of lung cancer. (citations omitted).

Dr. Naeye has been board-certified in anatomic and clinical pathology since 1960. He currently serves as the Professor of Pathology at The Pennsylvania State University College of Medicine. He has served on the editorial board of several medical journals and has been the author of a significant number of medical publications, including publications regarding the effects of coal dust and/or smoking on miners.

Discussion

Of the physicians offering opinions in this case, Drs. Smiddy, Miller, and Barongan diagnose the presence of pneumoconiosis and/or chronic obstructive lung disease in addition to lung cancer. They do not, however, offer any reasoning for their findings on the etiology of these conditions. Dr. Perper concludes that the miner suffered from simple coal workers' pneumoconiosis as well as lung cancer, centrilobular emphysema, and chronic obstructive pulmonary disease stemming from the miner's exposure to coal dust. Drs. Forehand, Dahhan, and Naeye, on the other hand, conclude that the miner did not suffer from any coal dust induced respiratory or pulmonary disease.

Dr. Perper diagnoses the presence of lung cancer, centrilobular emphysema, and chronic obstructive pulmonary disease. There is testing and data of record to support his findings of lung cancer and chronic obstructive pulmonary disease. However, while there is occasional reference to *emphysema* in the miner's treatment records, there is no medical data, testing, or treating physician's report diagnosing the presence of *centrilobular emphysema*. As a result, Dr. Perper's diagnosis of this ailment is not well-documented. *Cosaltar v. Mathies Coal Co.*, 6 B.L.R. 1-1182 (1984) (a physician's opinion may be accorded less weight where the basis for the opinion cannot be determined).

Dr. Perper then finds that the miner's lung cancer, centrilobular emphysema, and chronic obstructive pulmonary disease were related to his coal dust exposure. While he cites to numerous publications and the Department's comments underlying its December 2000 amendments to the regulations in support of his position that coal dust exposure can cause these ailments, Dr. Perper fails to provide a well-reasoned opinion demonstrating such a causal nexus in this case. Indeed, Dr. Perper's conclusion that the miner's lung cancer is related, in part, to his exposure to coal dust seems to rest on his presumption that the miner suffered from simple coal workers' pneumoconiosis and significant exposure to silica. Dr. Naeye takes issue with these assumptions and, as discussed below, he does not find medical support in the record for the assumptions. The undersigned agrees that, generally, lung cancer, centrilobular emphysema, and chronic obstructive lung disease may be deemed due to coal dust exposure. However, there must be adequate medical reasoning and documentation in support of such conclusions, which is lacking in this particular case. *Knizer v. Bethlehem Mines Corp.*, 8 B.L.R. 1-5 (1985) (a medical opinion based on generalities, rather than focusing on the miner's specific condition, may be accorded less weight).

In support of his diagnoses of coal workers' pneumoconiosis, Dr. Perper cites to Dr. DePonte's finding of pneumoconiosis on chest x-ray and CT-scan evidence. Even applying the rebuttable presumption that the diagnosed pneumoconiosis under § 718.202(a)(1) arose from coal dust exposure under § 718.203, Dr. Perper's opinion loses probative force. This is because a preponderance of the chest x-ray and CT-scan evidence support diagnoses of lung cancer and/or chronic obstructive pulmonary disease, but they do not support a finding of pneumoconiosis. Dr. Perper cites to Dr. DePonte's finding of Category 1 pneumoconiosis on the January 2003 x-ray study. However, Dr. Perper did not have the benefit of considering Dr. Wheeler's negative interpretation of the same study. Further, Dr. DePonte's interpretations of previous and subsequent studies do not contain any further findings of Category 1 pneumoconiosis. She consistently interprets those studies as revealing chronic obstructive

pulmonary disease of unstated etiology and a mass suspicious for lung cancer. Dr. Perper's opinion is accorded less weight as he does not adequately explain his findings of coal workers' pneumoconiosis based on the foregoing data.

Next, Dr. Perper stated that Dr. Miller diagnosed coal workers' pneumoconiosis in certain reports. Dr. Miller diagnosed pneumoconiosis, chronic obstructive lung disease, and lung cancer among other ailments. But while Dr. Miller's diagnosis of lung cancer and chronic obstructive lung disease are supported by various chest x-rays, CT-scans, and/or bronchoscopy evidence of record, the record is lacking in support of his diagnosis of pneumoconiosis. Indeed, Dr. Miller does not explain his diagnosis of pneumoconiosis and, in fact, Dr. Miller's April and May 2003 reports do not contain any diagnosis of pneumoconiosis. *See Cosaltar, supra.* The lack of documentation and reasoning to support Dr. Miller's diagnosis of pneumoconiosis, or any other coal dust induced disease, limits the probative value that can be accorded Dr. Perper's opinion.[6]

On the other hand, the opinions of Drs. Forehand, Dahhan, and Naeye, persuasively conclude that the miner suffered from neither clinical nor legal coal workers' pneumoconiosis and their reports are well-reasoned and well-documented on this record. Dr. Forehand conducted an examination in October 2002, shortly before the miner was first diagnosed with lung cancer. At the time, Dr. Forehand concluded that the chest x-ray did not reveal the presence of coal workers' pneumoconiosis, but he found a suspicious mass and recommended additional testing for tuberculosis and cancer. Ventilatory and blood gas testing yielded non-qualifying results. Dr. Forehand opined that the miner did not suffer from coal workers' pneumoconiosis or any respiratory impairment. His opinion is internally consistent and well-reasoned and well-documented. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989) (en banc). Moreover, it is more in accord with the objective medical data of record than Dr. Perper's report, *i.e.* x-rays that preponderantly do not demonstrate the presence of pneumoconiosis. *Minnich v. Pagnotti Enterprises, Inc.*, 9 B.L.R. 1-89, 1-90 n. 1 (1986) (a report that is better in accord with the objective medical data of record may be given greater weight). Similarly, Dr. Dahhan's finding of no coal workers' pneumoconiosis, based on his review of the treatment and hospitalization records, is reasoned and documented.

Dr. Naeye's report is the most well-reasoned and well-documented on this record. He conducted the most thorough review of the medical data on this record, including (1) Dr. Forehand's October 2002 examination and testing; (2) subsequent treatment records and testing that focused primarily on treatment of the miner's lung cancer; (3) the miner's terminal hospitalization records; and (4) two tissue samples from the miner's lungs, which Dr. Naeye analyzed and found to be absent of evidence of fibrogenic silica or coal workers' pneumoconiosis. From this, he opines that "[t]oxic silica being absent, coal mine dust could not

[6] The same rationale holds true for Dr. Baluyot's diagnosis of "pneumoconiosis" as a primary cause of death on the miner's death certificate. The Board has held that a death certificate, standing alone, is an unreliable report of the miner's condition. Further, it is error for an administrative law judge to accept conclusions contained in the death certificate where, as in this case, the record provides no indication that Dr. Baluyot possessed sufficient personal knowledge of the miner from which to assess the cause of death, particularly since there was no autopsy performed. *Smith v. Camco Mining, Inc.*, 13 B.L.R. 1-17 (1989); *Addison v. Director, OWCP*, 11 B.L.R. 1-68 (1988). *See also Bill Branch Coal Corp. v. Sparks*, 213 F.3d 186 (4th Cir. 2000) (a death certificate stating that pneumoconiosis contributed to the miner's death, without some further explanation, is insufficient).

have caused significant emphysema as claimed by Dr. Perper. He concluded that the medical data of record did not support a finding of coal workers' pneumoconiosis. In contrast, Dr. Perper did not conduct an analysis of the tissue samples from the miner's lungs, rather he reviewed the pathology report for the bronchoscopy, which did not contain findings of pneumoconiosis. Given that Dr. Naeye reviewed more medical data than Dr. Perper, including first-hand analysis of tissue from the miner's lungs, and because Dr. Naeye's conclusions are better supported by this data, it is determined that his report carries the greatest weight. *Sabett v. Director, OWCP*, 7 B.L.R. 1-299 (1984) (greater weight may be accorded an opinion that is supported by more extensive documentation over the opinions supported by limited medical data).

In sum, Claimant has not established the presence of coal workers' pneumoconiosis through well-reasoned, well-documented medical opinions or through CT-scan evidence under 20 C.F.R. § 718.202(a)(4). Moreover, a weighing of all of the evidence together, as required by the Fourth Circuit in *Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000), necessitates a finding of no coal workers' pneumoconiosis as a preponderance of the x-rays, biopsy and CT scan evidence do not support a finding of coal workers' pneumoconiosis. Because Claimant has not established the presence of coal workers' pneumoconiosis by a preponderance of the evidence, benefits must be denied. Accordingly,

## ORDER

IT IS ORDERED that the claims for benefits filed by Sandra K. Stidham and James Stidham are denied.

A

Thomas M. Burke
Associate Chief Administrative Law Judge

**NOTICE OF APPEAL RIGHTS:** If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is:

**Benefits Review Board**
**U.S. Department of Labor**
**P.O. Box 37601**
**Washington, DC 20013-7601**

Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board,

unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481. If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).